

<i>SERFF Tracking Number:</i>	<i>AEGX-125669134</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Transamerica Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>39136</i>
<i>Company Tracking Number:</i>	<i>TLSD1000IPA.AR VERAP</i>		
<i>TOI:</i>	<i>H07I Individual Health - Specified Disease - Limited Benefit</i>	<i>Sub-TOI:</i>	<i>H07I.001 Critical Illness</i>
<i>Product Name:</i>	<i>Critical Illness</i>		
<i>Project Name/Number:</i>	<i>Critical Illness/HS AR0041507F01</i>		

Filing at a Glance

Company: Transamerica Life Insurance Company

Product Name: Critical Illness SERFF Tr Num: AEGX-125669134 State: ArkansasLH

TOI: H07I Individual Health - Specified Disease SERFF Status: Closed State Tr Num: 39136
- Limited Benefit

Sub-TOI: H07I.001 Critical Illness Co Tr Num: TLSD1000IPA.AR VERAP State Status: Approved-Closed

Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: SPI ADMSLH	Disposition Date: 06/04/2008
	Date Submitted: 05/28/2008	Disposition Status: Approved-Closed

Implementation Date Requested: Implementation Date:

State Filing Description:

General Information

Project Name: Critical Illness

Project Number: HS AR0041507F01

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 06/04/2008

State Status Changed: 06/04/2008

Corresponding Filing Tracking Number:

Filing Description:

Transamerica Life Insurance Company

NAIC # 0468-86231

FEIN: 39-0989781

TLSD1000IPA.AR VERAPP

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type:

Group Market Size:

Group Market Type:

Deemer Date:

<i>SERFF Tracking Number:</i>	<i>AEGX-125669134</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Transamerica Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>39136</i>
<i>Company Tracking Number:</i>	<i>TLSD1000IPA.AR VERAP</i>		
<i>TOI:</i>	<i>H071 Individual Health - Specified Disease - Limited Benefit</i>	<i>Sub-TOI:</i>	<i>H071.001 Critical Illness</i>
<i>Product Name:</i>	<i>Critical Illness</i>		
<i>Project Name/Number:</i>	<i>Critical Illness/HS AR0041507F01</i>		

Attached for your review and approval is a copy of the above captioned form. This form is new and does not replace any form previously approved by your Department. This form has been completed in "John Doe" fashion. Variable information is bracketed and printed in red.

Individual Application Verification Form TLSD1000IPA.AR VERAPP will be used to solicit Individual Critical Illness Policy TLSD1000IP.AR, approved by your Department on September 19, 2007. This form may also be used with other similar products as they become approved by the Department. This form will be sent to Insureds who apply via telemarketing methods for their records.

We request approval of this form in various format, dimensions, shading and colors. We certify that no dimension, format, shading or color change will affect the text content or product unacceptable print. Completed filing forms are attached.

Company and Contact

Filing Contact Information

Mat Thekkil, Contract Analyst
2700 W Plano Parkway
Plano, TX 75075

mthekkil@aegonusa.com
(972) 881-6452 [Phone]
(972) 881-4097[FAX]

Filing Company Information

Transamerica Life Insurance Company
4333 Edgewood Road, N.E.
Cedar Rapids, IA 52499
(410) 685-5500 ext. [Phone]

CoCode: 86231
Group Code: 468
Group Name:
FEIN Number: 39-0989781

State of Domicile: Iowa
Company Type:
State ID Number:

Filing Fees

Fee Required? Yes

<i>SERFF Tracking Number:</i>	<i>AEGX-125669134</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Transamerica Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>39136</i>
<i>Company Tracking Number:</i>	<i>TLSD1000IPA.AR VERAP</i>		
<i>TOI:</i>	<i>H071 Individual Health - Specified Disease - Limited Benefit</i>	<i>Sub-TOI:</i>	<i>H071.001 Critical Illness</i>
<i>Product Name:</i>	<i>Critical Illness</i>		
<i>Project Name/Number:</i>	<i>Critical Illness/HS AR0041507F01</i>		
Fee Amount:	\$50.00		
Retaliatory?	No		
Fee Explanation:			
Per Company:	No		

<i>SERFF Tracking Number:</i>	<i>AEGX-125669134</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Transamerica Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>39136</i>
<i>Company Tracking Number:</i>	<i>TLSD1000IPA.AR VERAP</i>		
<i>TOI:</i>	<i>H071 Individual Health - Specified Disease -</i>	<i>Sub-TOI:</i>	<i>H071.001 Critical Illness</i>
	<i>Limited Benefit</i>		
<i>Product Name:</i>	<i>Critical Illness</i>		
<i>Project Name/Number:</i>	<i>Critical Illness/HS AR0041507F01</i>		

CHECK NUMBER	CHECK AMOUNT	CHECK DATE
7010065144	\$50.00	05/23/2008

SERFF Tracking Number:	AEGX-125669134	State:	Arkansas
Filing Company:	Transamerica Life Insurance Company	State Tracking Number:	39136
Company Tracking Number:	TLSD1000IPA.AR VERAP		
TOI:	H071 Individual Health - Specified Disease - Limited Benefit	Sub-TOI:	H071.001 Critical Illness
Product Name:	Critical Illness		
Project Name/Number:	Critical Illness/HS AR0041507F01		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/04/2008	06/04/2008

Amendments

Item	Schedule	Created By	Created On	Date Submitted
TLSD1000IP Form A.AR VERAPP - Application Verification		SPI ADMSLH	06/03/2008	06/03/2008

<i>SERFF Tracking Number:</i>	<i>AEGX-125669134</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Transamerica Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>39136</i>
<i>Company Tracking Number:</i>	<i>TLSD1000IPA.AR VERAP</i>		
<i>TOI:</i>	<i>H071 Individual Health - Specified Disease - Limited Benefit</i>	<i>Sub-TOI:</i>	<i>H071.001 Critical Illness</i>
<i>Product Name:</i>	<i>Critical Illness</i>		
<i>Project Name/Number:</i>	<i>Critical Illness/HS AR0041507F01</i>		

Disposition

Disposition Date: 06/04/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AEGX-125669134 State: Arkansas

Filing Company: Transamerica Life Insurance Company State Tracking Number: 39136

Company Tracking Number: TLSD1000IPA.AR VERAP

TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.001 Critical Illness
Limited Benefit

Product Name: Critical Illness

Project Name/Number: Critical Illness/HS AR0041507F01

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	AR - NAIC TRANSMITTAL DOC, AR - NAIC FORM FILING ATTACHMENT	Approved-Closed	Yes
Form (revised)	TLSD1000IPA.AR VERAPP - Application Verification	Approved-Closed	Yes
Form	TLSD1000IPA.AR VERAPP - Application Verification	Withdrawn	No

SERFF Tracking Number: AEGX-125669134 State: Arkansas

Filing Company: Transamerica Life Insurance Company State Tracking Number: 39136

Company Tracking Number: TLSD1000IPA.AR VERAP

TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.001 Critical Illness
Limited Benefit

Product Name: Critical Illness

Project Name/Number: Critical Illness/HS AR0041507F01

Amendment Letter

Amendment Date:

Submitted Date: 06/03/2008

Comments:

Per a discussion within our department, please find the amended form attached. We have amended the form to make verification form clearer. Thank you.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
TLSD1000IP Application/ETLSD1000IP Revised A.AR nrollment Form	A.AR VERAPP - Application Verification						0	TLSD1000IPA_AR VERAPP.PDF

SERFF Tracking Number: *AEGX-125669134* *State:* *Arkansas*
Filing Company: *Transamerica Life Insurance Company* *State Tracking Number:* *39136*
Company Tracking Number: *TLSD1000IPA.AR VERAP*
TOI: *H071 Individual Health - Specified Disease - Limited Benefit* *Sub-TOI:* *H071.001 Critical Illness*
Product Name: *Critical Illness*
Project Name/Number: *Critical Illness/HS AR0041507F01*

Form Schedule

Lead Form Number: TLSD1000IPA.AR VERAPP

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	TLSD1000IPA.AR VERAPP	Application/Enrollment Form	TLSD1000IPA.AR VERAPP - Application Verification	Revised	Replaced Form #: Previous Filing #:	0	TLSD1000IPA_AR_VERAPP.PDF

[Critical Illness Insurance]
Application Verification

Keep this form with your Policy. Your acceptance of this offer is on file at our Administrative Office.

This document is a verification record of your telephone-recorded application for the [Critical Illness Insurance Plan]. It is designed to help you verify that we have correctly recorded your name, address, [date of birth,] [gender,] [height] [and] [weight] and the answers you provided to the health questions which qualified you for this plan.

Our records indicate the following information:

Name/Address: [John Q. Public]
[1000 Anywhere Street]
[Any Town, USA 75000]
[johnqpublic@email.com]

[Date of Birth:] [01/05/1968] [Gender:] [Male]

[Height:] [5'10"] [Weight:] [185 lbs.]

Are you currently eligible to receive Medicare benefits? ☐ Yes ☒ No

Will this policy replace any accident or health insurance policy that you now have in force? ☐ Yes ☒ No

I wish to add the Return of Premium Rider. ☒ Yes ☐ No

Health Questions

Response

1. Have you ever been diagnosed or treated by a physician or other medical practitioner for: a. Cancer, tumor, Hodgkin's disease, lymphoma, leukemia or melanoma? b. Heart attack, angina, high blood pressure, transient ischemic attack (TIA), (mini stroke), stroke or any other disease or disorder of the heart, aorta, arteries or circulatory system? c. Diabetes, paralysis, hepatitis or any other disease or disorder of the lungs, brain, kidney, liver or nervous system?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
2. Have you ever been diagnosed with or told you have Acquired Immune Deficiency Syndrome (AIDS) or are infected with the HIV (AIDS) virus?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
3. Have your parents or siblings (brothers, sisters) been diagnosed with or died from cancer, heart attack, heart disease, stroke or diabetes before age 60?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
4. Have you used any tobacco or nicotine based products on any basis within the last 12 months?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

I represent that my above answers are true and complete to the best of my knowledge and belief. I understand that incorrect or misleading answers (material misrepresentations) to any of the questions may void the application during the first 24 months of coverage. I understand [a separate Policy will be issued to each applicant and] that no insurance is in effect until Transamerica Life Insurance Company issues my Policy and receives my first premium before the Policy Effective Date.

I understand that the Policy only covers specified Critical Illnesses that are first diagnosed after the Policy Effective Date. I understand that a limited benefit is paid for a Critical Illness that is first diagnosed during the first 30 days of coverage. I also understand that any Critical Illness caused by or resulting from a pre-existing condition that I received medical treatment for during the 12 month period prior to the Effective Date will not be covered during the first 12 months of coverage. I understand that I cannot be covered by this Policy if I am also covered by any Title XIX program. I further understand that I can have only one Policy/Certificate providing the same or similar coverage. I have read [the fraud statements [below] [on the back of] this application and] the NOTICE TO APPLICANT enclosed with this form as required by the Fair Credit Reporting Act.

Transamerica Life Insurance Company
Home Office: Cedar Rapids, Iowa

TLSD1000IPA.AR VERAPP

Administrative Office: [2700 West Plano Parkway, Plano, Texas 75075-8200]

Authorization for disclosures of medical information to Transamerica Life Insurance Company

I understand I am not required to sign this authorization; however, without it Transamerica Life Insurance Company can not achieve two purposes, (1) its underwriters can not determine my eligibility for insurance; and (2) its claim adjusters may not be able to pay my claim. I authorize any medical practitioner, medical related institution, government agency, paramedic facility, medical record retrieval services, pharmaceutical services, insurance company, reinsurer, plan administrator, the Medical Information Bureau, or any Consumer Reporting Agency, to disclose to Transamerica Life Insurance Company all of my medical records except psychotherapy notes (e.g., my medical history, diagnoses, symptoms, treatments, prescription drug information, alcohol or drug or tobacco use or abuse or information regarding communicable or infectious conditions, such as AIDS). I understand that entities to which this information may be disclosed may not be covered by federal privacy rules and if this information is redisclosed, it may no longer be protected by those rules. I understand this authorization or a copy: (1) expires 24 months from the date signed or if earlier, upon completion of any claim for benefits; (2) a copy will be sent to me; and (3) I may revoke it in writing at any time by sending written notice to Transamerica Life Insurance Company [2700 West Plano Parkway, Plano, Texas 75075-8200] except to the extent it is already relied upon.

The Policy provides limited benefits. Review your Policy carefully.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

[Application signed electronically. Signature on file with the Company ____]
[Applicant's Signature]

If any of the information is incorrect, contact our Customer Service Department at: [1-800-XXX-XXXX]

Transamerica Life Insurance Company
Home Office: Cedar Rapids, Iowa

TLSD1000IPA.AR VERAPP

Administrative Office: [2700 West Plano Parkway, Plano, Texas 75075-8200]

<i>SERFF Tracking Number:</i>	<i>AEGX-125669134</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Transamerica Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>39136</i>
<i>Company Tracking Number:</i>	<i>TLSD1000IPA.AR VERAP</i>		
<i>TOI:</i>	<i>H071 Individual Health - Specified Disease - Limited Benefit</i>	<i>Sub-TOI:</i>	<i>H071.001 Critical Illness</i>
<i>Product Name:</i>	<i>Critical Illness</i>		
<i>Project Name/Number:</i>	<i>Critical Illness/HS AR0041507F01</i>		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	AEGX-125669134	State:	Arkansas
Filing Company:	Transamerica Life Insurance Company	State Tracking Number:	39136
Company Tracking Number:	TLSD1000IPA.AR VERAP		
TOI:	H071 Individual Health - Specified Disease - Limited Benefit	Sub-TOI:	H071.001 Critical Illness
Product Name:	Critical Illness		
Project Name/Number:	Critical Illness/HS AR0041507F01		

Supporting Document Schedules

Satisfied -Name:	Certification/Notice	Review Status:	Approved-Closed	06/04/2008
Comments:				
Attachment:	AR - READABILITY CERTIFICATION.PDF			
Satisfied -Name:	Application	Review Status:	Approved-Closed	06/04/2008
Comments:	Attached to Form Schedule			
Bypassed -Name:	Health - Actuarial Justification	Review Status:	Approved-Closed	06/04/2008
Bypass Reason:	N/A			
Comments:				
Bypassed -Name:	Outline of Coverage	Review Status:	Approved-Closed	06/04/2008
Bypass Reason:	N/A			
Comments:				
Satisfied -Name:	Cover Letter	Review Status:	Approved-Closed	06/04/2008
Comments:	Cover Letter			
Attachment:	Cover Letter.PDF			
Satisfied -Name:	AR - NAIC TRANSMITTAL DOC, AR - NAIC FORM FILING	Review Status:	Approved-Closed	06/04/2008

SERFF Tracking Number: AEGX-125669134 State: Arkansas
Filing Company: Transamerica Life Insurance Company State Tracking Number: 39136
Company Tracking Number: TLSD1000IPA.AR VERAP
TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.001 Critical Illness
Limited Benefit
Product Name: Critical Illness
Project Name/Number: Critical Illness/HS AR0041507F01

ATTACHMENT

Comments:

NAIC Transmittal

Attachments:

AR - NAIC TRANSMITTAL DOC.PDF

AR - NAIC FORM FILING ATTACHMENT.PDF

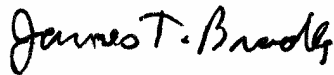
STATE OF ARKANSAS
READABILITY CERTIFICATION

COMPANY NAME: Transamerica Life Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
TLSD1000IPA.AR VERAPP	47.3

Signed: _____



Name: James T. Bradley

Title: Assistant Secretary

Date: 05/22/08



Administrative Office | 2700 W. Plano Parkway | Plano | Texas 75075

May 22, 2008

The Honorable Julie Benafield Bowman
Commissioner of Insurance
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

Attn: Mr. John Shields

RE: Transamerica Life Insurance Company
NAIC # 0468-86231
FEIN: 39-0989781
TLSD1000IPA.AR VERAPP

Dear Commissioner:

Attached for your review and approval is a copy of the above captioned form. This form is new and does not replace any form previously approved by your Department. This form has been completed in "John Doe" fashion. Variable information is bracketed and printed in red.

Individual Application Verification Form TLSD1000IPA.AR VERAPP will be used to solicit Individual Critical Illness Policy TLSD1000IP.AR, approved by your Department on September 19, 2007. This form may also be used with other similar products as they become approved by the Department. This form will be sent to Insureds who apply via telemarketing methods for their records.

We request approval of this form in various format, dimensions, shading and colors. We certify that no dimension, format, shading or color change will affect the text content or product unacceptable print. Completed filing forms are attached.

I respectfully request your favorable review and approval. We appreciate your consideration of this form. Should you have any questions, please feel free to call us toll free at (877) 527-6444, Extension 6452 or contact me by e-mail at mthekkil@aegonusa.com.

Sincerely,

TRANSAMERICA LIFE INSURANCE COMPANY

A handwritten signature in black ink that reads "Mat Thekkil". The signature is written in a cursive, flowing style.

Mat Thekkil, FLMI, FFSI, CCP, PCS, AAPA, AIAA, AIRC, ARA
Contract Analyst

Attachments

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	Arkansas
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2.	Department Use Only
	State Tracking ID

3.	Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
	Transamerica Life Insurance Company 2700 W Plano Parkway Plano TX 75075	IA		468	86231	39-0989781	

4.	Contact Name & Address	Telephone #	Fax #	E-mail Address
	Mat Thekkil 2700 W Plano Parkway Plano TX 75075	877-527-6444 Ext. 6452	972-881-4097	mthekkil@aegonusa.com

5.	Requested Filing Mode	<input checked="" type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
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6.	Company Tracking Number	TLSD1000IPA.AR VERAP
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7.	<input checked="" type="checkbox"/> New Submission <input type="checkbox"/> Resubmission	Previous file # _____
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8.	Market	<input checked="" type="checkbox"/> Individual <input type="checkbox"/> Franchise <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Small <input type="checkbox"/> Large <input type="checkbox"/> Small and Large <input type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____ </div> <div>Group</div> </div>
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9.	Type of Insurance	H07I Individual Health - Specified Disease - Limited Benefit
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10.	Product Coding Matrix Filing Code	H07I.001 Critical Illness
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11.	Submitted Documents	<input checked="" type="checkbox"/> <u>FORMS</u> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Policy <input checked="" type="checkbox"/> Application/Enrollment <input type="checkbox"/> Schedule of Benefits </div> <div> <input type="checkbox"/> Outline of Coverage <input type="checkbox"/> Rider/Endorsement <input type="checkbox"/> Other: _____ </div> <div> <input type="checkbox"/> Certificate <input type="checkbox"/> Advertising </div> </div> <input type="checkbox"/> <u>RATES</u> <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate
		<input type="checkbox"/> <u>FILING OTHER THAN FORM OR RATE:</u> Please explain: _____
		<u>SUPPORTING DOCUMENTATION</u> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Association Bylaws <input type="checkbox"/> Statement of Variability <input type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other: _____ </div> <div> <input type="checkbox"/> Third Party Authorization <input type="checkbox"/> Trust Agreement <input type="checkbox"/> Certifications </div> </div>

12.	Filing Submission Date	05/22/08
13.	Filing Fee (If required)	Amount _____ Check Date _____ Retaliatory <input type="checkbox"/> Yes <input type="checkbox"/> No Check Number _____
14.	Date of Domiciliary Approval	
15.	Filing Description:	
	<p>Transamerica Life Insurance Company NAIC # 0468-86231 FEIN: 39-0989781 TLSD1000IPA.AR VERAPP</p> <p>Attached for your review and approval is a copy of the above captioned form. This form is new and does not replace any form previously approved by your Department. This form has been completed in "John Doe" fashion. Variable information is bracketed and printed in red.</p> <p>Individual Application Verification Form TLSD1000IPA.AR VERAPP will be used to solicit Individual Critical Illness Policy TLSD1000IP.AR, approved by your Department on September 19, 2007. This form may also be used with other similar products as they become approved by the Department. This form will be sent to Insureds who apply via telemarketing methods for their records.</p> <p>We request approval of this form in various format, dimensions, shading and colors. We certify that no dimension, format, shading or color change will affect the text content or product unacceptable print. Completed filing forms are attached.</p>	

16.	Certification (If required)	
<p>I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of <u>Arkansas</u>.</p> <p>Print Name <u>Mat Thekkil</u> Title <u>Contract Analyst</u></p> <p>Signature  Date <u>05/22/08</u></p>		

17.	Form Filing Attachment	
This filing transmittal is part of company tracking number		TLSD1000IPA.AR VERAP
This filing corresponds to rate filing company tracking number		

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	TLSD1000IPA.AR VERAPP - Application Verification	TLSD1000IPA.AR VERAPP	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
02			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
11			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	

<i>SERFF Tracking Number:</i>	<i>AEGX-125669134</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Transamerica Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>39136</i>
<i>Company Tracking Number:</i>	<i>TLSD1000IPA.AR VERAP</i>		
<i>TOI:</i>	<i>H071 Individual Health - Specified Disease - Limited Benefit</i>	<i>Sub-TOI:</i>	<i>H071.001 Critical Illness</i>
<i>Product Name:</i>	<i>Critical Illness</i>		
<i>Project Name/Number:</i>	<i>Critical Illness/HS AR0041507F01</i>		

Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	TLSD1000IPA.AR VERAPP - Application Verification	05/28/2008	TLSD1000IPA_AR VERAPP.PDF

[Critical Illness Insurance]
Application Verification

Keep this form with your Policy. Your acceptance of this offer is on file at our Administrative Office.

This document is a verification record of your telephone-recorded application for the [Critical Illness Insurance Plan]. It is designed to help you verify that we have correctly recorded your name, address, [date of birth,] [gender,] [height] [and] [weight] and the answers you provided to the health questions which qualified you for this plan.

Our records indicate the following information:

Name/Address: [John Q. Public]
[1000 Anywhere Street]
[Any Town, USA 75000]
[johnqpublic@email.com]

[Date of Birth:] [01/05/1968] [Gender:] [Male]

[Height:] [5'10"] [Weight:] [185 lbs.]

[Tobacco User: ☐ Yes ☒ No]

Are you currently eligible to receive Medicare benefits? ☐ Yes ☒ No

Will this policy replace any accident or health insurance policy that you now have in force? ☐ Yes ☒ No

I wish to add the Return of Premium Rider. ☒ Yes ☐ No

Health Questions

Response

1. Have you ever been diagnosed or treated by a physician or other medical practitioner for: a. Cancer, tumor, Hodgkin's disease, lymphoma, leukemia or melanoma? b. Heart attack, angina, high blood pressure, transient ischemic attack (TIA), (mini stroke), stroke or any other disease or disorder of the heart, aorta, arteries or circulatory system? c. Diabetes, paralysis, hepatitis or any other disease or disorder of the lungs, brain, kidney, liver or nervous system?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
2. Have you ever been diagnosed with or told you have AIDS or are infected with the HIV (AIDS) virus?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
3. Have your parents or siblings (brothers, sisters) been diagnosed with or died from cancer, heart attack, heart disease, stroke or diabetes before age 60?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

I represent that my above answers are true and complete to the best of my knowledge and belief. I understand that incorrect or misleading answers (material misrepresentations) to any of the questions may void the application during the first 24 months of coverage. I understand [a separate Policy will be issued to each applicant and] that no insurance is in effect until Transamerica Life Insurance Company issues my Policy and receives my first premium before the Policy Effective Date.

I understand that the Policy only covers specified Critical Illnesses that are first diagnosed after the Policy Effective Date. I understand that a limited benefit is paid for a Critical Illness that is first diagnosed during the first 30 days of coverage. I also understand that any Critical Illness caused by or resulting from a pre-existing condition that I received medical treatment for during the 12 month period prior to the Effective Date will not be covered during the first 12 months of coverage. I understand that I cannot be covered by this Policy if I am also covered by any Title XIX program. I further understand that I can have only one Policy/Certificate providing the same or similar coverage. I have read [the fraud statements [below] [on the back of] this application and] the NOTICE TO APPLICANT enclosed with this form as required by the Fair Credit Reporting Act.

Transamerica Life Insurance Company
Home Office: Cedar Rapids, Iowa

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Administrative Office: [2700 West Plano Parkway, Plano, Texas 75075-8200]

Authorization for disclosures of medical information to Transamerica Life Insurance Company

I understand I am not required to sign this authorization; however, without it Transamerica Life Insurance Company can not achieve two purposes, (1) its underwriters can not determine my eligibility for insurance; and (2) its claim adjusters may not be able to pay my claim. I authorize any medical practitioner, medical related institution, government agency, paramedic facility, medical record retrieval services, pharmaceutical services, insurance company, reinsurer, plan administrator, the Medical Information Bureau, or any Consumer Reporting Agency, to disclose to Transamerica Life Insurance Company all of my medical records except psychotherapy notes (e.g., my medical history, diagnoses, symptoms, treatments, prescription drug information, alcohol or drug or tobacco use or abuse or information regarding communicable or infectious conditions, such as AIDS). I understand that entities to which this information may be disclosed may not be covered by federal privacy rules and if this information is redisclosed, it may no longer be protected by those rules. I understand this authorization or a copy: (1) expires 24 months from the date signed or if earlier, upon completion of any claim for benefits; (2) a copy will be sent to me; and (3) I may revoke it in writing at any time by sending written notice to Transamerica Life Insurance Company [2700 West Plano Parkway, Plano, Texas 75075-8200] except to the extent it is already relied upon.

The Policy provides limited benefits. Review your Policy carefully.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

[Application signed electronically. Signature on file with the Company ____]
[Applicant's Signature]

If any of the information is incorrect, contact our Customer Service Department at: [1-800-XXX-XXXX]

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